01294

422.2
93d

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 4yr.2mos.25days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): none

3. NAME OF DECEASED (Type or Print)	(First) Ethel	(Middle)	(Last) Adams	4. DATE OF DEATH	(Month) 2/ (Day) 23/49 (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: 1877	9. AGE last birthday: 72 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Charles County, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S		
13. FATHER'S NAME: Thomas Gray	14. MOTHER'S MAIDEN NAME: Georginana Mason				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myodegeneratio Cordis	known to us since 11/2/44
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Senile Psychosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/2/44, 19....., to 2/23/49, 19....., that I last saw the deceased alive on 2/23/49, 19....., and that death occurred at 1:40 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	2/23/49

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: 2/28/49	NAME OF CEMETERY OR CREMATORY: Strathmore	LOCATION (City, town, or county) (State): Annapolis, Md.
DATE REC'D BY LOCAL REG.: 2/25/49	REGISTRAR'S SIGNATURE: E.F. Joyce - Local Reg.	24. FUNERAL DIRECTOR: Mrs Hicks, Chas. E. Annapolis, Md.	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
MAR 1 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

603 133b 01295

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAMBRILLS, R.F.D. LENGTH OF STAY (in this place) 4 MO
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crain Highway (south of Millersville)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GAMBRILLS, R.F.D.
STREET ADDRESS (If rural give location) Crain Highway (Benshaws Tavern)

3. NAME OF DECEASED (Type or Print) (First) JOSEPH (Middle) F. (Last) AMELING.

4. DATE OF DEATH (Month) FEB. (Day) 20 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWER
8. DATE OF BIRTH Sept. 7, 1859
9. AGE last birthday 89 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)
10b. KIND OF BUSINESS OR INDUSTRY OWN FARM
11. BIRTHPLACE (State or foreign country) GERMANY.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Mrs Louise Benshaw

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.

Immediate cause (a) Uraemic poisoning.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Kidney disfunction

(c) disfunction

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-18, 1948 to 2-20, 1948 that I last saw the deceased alive on Feb 19, 1949 and that death occurred at 12.15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
O H Mac Neman M D. 2-21-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE FEB. 23, 1949
NAME OF CEMETERY OR CREMATORY Our Lady of the field
LOCATION (City, town, or county) (State) MILLERSVILLE, MD.

DATE REC'D BY LOCAL REG. 2/24/49
REGISTRAR'S SIGNATURE L. J. De Alba
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 24 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

177 51b 0129625

Reg. Dist. No. ~~23~~

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: a.a.

City or town: Brooklyn
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 53II Ballman Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Christian Frederick Ballman Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Annie M. Biemiller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): I2/26/I864

8. AGE:

Years	Months	Days	If less than one day
84	I	7	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Self

FATHER
12. Name: Henry Ballman
13. Birthplace: Germany

MOTHER
14. Maiden name: Annie Schultz
15. Birthplace: Germany

16. Informant: Family
Address: Same

17. B (Burial, cremation, or removal. Which?) Date thereof: 2/7/49 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Brooklyn

18. Funeral director: James L. McCauley
Address: I30 East Fort Avenue

19. 2-7 19 49 A H Hedrick
(Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1949, at 8:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1944 to Feb 3 1949 and that I last saw him alive on Feb 2 1949

Immediate cause of death: generalized carcinomatosis

Due to: prostatic carcinoma

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Philip W. Kirstor MD
M. D. or other

Address: 302 Patapsco Cir Date signed: 2-4-49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

162 47C

01297

CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marley Neck Rd. #26	STREET ADDRESS (If rural, give location) Marley Neck Rd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGE	E.	BELL, Jr.	Feb.	8	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	July 12, 1900	48 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hoister	Standard Wholesale Phosphate Co.	Balto., Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George E. Bell, Sr.	Elizabeth Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	
no	212-03-5764	Mrs. Mildred Bell	A. A. Co., Md. Marley Neck Rd.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Heart Failure — 2 days

Antecedent cause(s) Bronchiogenic.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Recurrent Lung with Metastases — 3 months

(c) to Pleura

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Novemb 1948, to Feb. 8, 1949, that I last saw the deceased alive on Feb. 7, 1949, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Brady Smith, M.D.		Riviera Beach, Md.	2/8/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/10/49	Cedar Hill Cem.	Balto., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/9/49	A. W. Hebeler JS	WM. J. TICKNER & SONS	Balto., Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

903.0

01298

CERTIFICATE OF DEATH 1860

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fort G. G. Meade
LENGTH OF STAY (in this place) dead on arrival
HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital Ft. Meade

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn
STREET ADDRESS (If rural, give location) Annapolis Road

3. NAME OF DECEASED (Type or Print): (First) Louise (Middle) Anna (Last) Brady
4. DATE OF DEATH: (Month) Feby (Day) 26 (Year) 1949
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): —
8. DATE OF BIRTH: Aug 6. 1948
9. AGE last birthday yrs.: Under 1 year — Months: 6 — Days: 20 — If under 24 hrs. — Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Carlisle Barracks, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: James K. Brady
14. MOTHER'S MAIDEN NAME: Nolan Moser
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If year, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: James K. Brady.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Strangulation

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: at home
CITY OR TOWN: Severn (COUNTY): A. A. (STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Feby 26, 1949 1½ p.m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Fell between wall & room and bed & strangulated.

22. I hereby certify that I ~~attended the deceased from~~ made Postmortem Examination, to Feby 26, 1949, ~~that I last saw the deceased alive on ..., 19..~~, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Claffey M.D. Deputy Medical Examiner, Annapolis, Maryland 2/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 1 Mar 1949
NAME OF CEMETERY OR CREMATORY: Rolling Green
LOCATION (City, town, or county) (State): Harrisburg, Penna.

DATE REC'D BY LOCAL REG.: 26 Feb 1949
REGISTRAR'S SIGNATURE: E. K. Burnside
E. K. BURNSIDE, CAPT., MSC
24. FUNERAL DIRECTOR: Dee Witt Donaldson
ADDRESS: Laurel, Md.

RECEIVED
MAR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 01299

806
93d

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md. LENGTH OF STAY (In this place): 71days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1311 Division Street

3. NAME OF DECEASED (Type or Print) (First) Arthur (Middle) (Last) Brandford			4. DATE OF DEATH (Month) February (Day) 9, (Year) 1949	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: 1880	9. AGE last birthday (ABT.) 68 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor	10b. KIND OF BUSINESS OR INDUSTRY: -------	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Joe Brandford		14. MOTHER'S MAIDEN NAME: Elizabeth Taylor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) ----	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Hospital Records, Crownsville State Hosp.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis known to us since 11/30/48

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Psychosis with Cerebral Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: -----	19b. MAJOR FINDINGS OF OPERATION: -------	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) ------	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ------	(CITY OR TOWN) ------- (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) ----- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? -------

22. I hereby certify that I attended the deceased from November 1948, to 2/9/, 1949, that I last saw the deceased alive on 2/9/, 1949, and that death occurred at 9:00 p.m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) ADDRESS: Crownsville, Maryland DATE SIGNED: February 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: 2-12-49	NAME OF CEMETERY OR CREMATORY: St. Rust. A.A. Co. Md	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. 2/10-49	REGISTRAR'S SIGNATURE: E. F. Joyce Local Regs.	24. FUNERAL DIRECTOR: James A. Hayes	ADDRESS: 142 W. Hill St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01300

970.2

CERTIFICATE OF DEATH

163 B

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville
LENGTH OF STAY (in this place) 2.5 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mountain Road

2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville
STREET ADDRESS (If rural, give location) Mountain Road.

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) (Last) Breit

4. DATE OF DEATH (Month) Feby. (Day) 19 (Year) 1949

5. SEX female

6. COLOR OR RACE White

7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH March 21, 1896

9. AGE last birthday 52 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Mrs. Lubov Keefer 3818 Tudor Arms Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Suicide

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Barbital narcosis

(c) Menopausal Melancholia

INTERVAL BETWEEN ONSET AND DEATH: several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home

(CITY OR TOWN) Jacobsville (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made Postmortem Examination to Feby. 19, 1949, ~~that I last saw the deceased alive on ....., 19....~~, and that death occurred at 11 45 p.m., from the causes and on the date stated above.

SIGNATURE John M. Claffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED Feby. 20, 1949.

23. BURIAL, CREMATION REMOVAL (Specify) Cremation DATE

NAME OF CEMETERY OR CREMATORY Greenmount Crematory

LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. 2/21/49

REGISTRAR'S SIGNATURE A. W. Hedrich

24. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS ~~3818 Tudor Arms Ave.~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01301

763.0

CERTIFICATE OF DEATH

109 Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY An. Ar. Co. Annapolis Md. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 41 Washington St. Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Annapolis COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural give location) 41 Washington St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) infant Brown

4. DATE OF DEATH (Month) 2 (Day) 14 (Year) 1949

5. SEX male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH Feb 13 1949
9. AGE last birthday ~~[illegible]~~ 1 day yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Theodore Brown
14. MOTHER'S MAIDEN NAME Hattie Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Theodore Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Aspiration Pneumonia

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Annapolis, (COUNTY) Md. (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-10-49, 19....., to 2-13-49, 19....., that I last saw the deceased alive on 2-13-49, 19....., and that death occurred at 12 P.M. m., from the causes and on the date stated above.

SIGNATURE F.W. Johnson M.D. (Degree or title) ADDRESS 40 Northwest Street Annapolis, Md DATE SIGNED 2/15/49

23. BURIAL, CREMATION REMOVAL (Specify) DATE Feb. 15, 1949 NAME OF CEMETERY OR CREMATORY Brewer Hill West St. LOCATION (City, town, or county) Annapolis Md. (State)

DATE REC'D BY LOCAL REG. Feb. 15, 1949 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR William Reese ADDRESS 108 Washington St. Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 16 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

162
47c

01302

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jacobsville, Pasadena, Md. P.O.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Jacobsville; Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Mountain Road
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: Victor Brumwell

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Marguerite Brumwell
Nee Lowery

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): March 18, 1897

8. AGE:

Years	Months	Days	If less than one day
51			..... hrs. ..... min.

9. Birthplace: Tilghman's Island
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: U.S. Coast Guard, Curtis Bay

FATHER
12. Name: Edward Brumwell
13. Birthplace

MOTHER
14. Maiden name: Margaret Lee
15. Birthplace

16. Informant: Roy Brumwell
Address: Jacobsville, Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 12, 1949 (month) (day) (year)

Cemetery or crematory: Meadowridge Cem.

Location: Dorsey, Md.

18. Funeral director: Thomas W. Singleton.
Address: GLEN BURNIE, MD.

19. 2/14 1949 (Date rec'd by registrar) L. J. Dralle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12 1949 at 8:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/22 1949 to Feb. 12 1949 and that I last saw him alive on Feb. 11 1949

Immediate cause of death	DURATION
Heart Failure	3 days
Due to Bronchiogenic Carcinoma	8 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other

Address: RIVIERA BEACH, MD Date signed: 2/14/49

RECEIVED
FEB 15 1949
BUREAU U. S.

Evidence for addition of # 21 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

9040 01303

~~450.0~~ 186a

Reg. Dist. No. 21

FILM No. G-126 MAY 24 1949

ANNE ARUNDEL CO.

1. PLACE OF DEATH: COUNTY MARYLAND — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Millersville — LENGTH OF STAY (in this place) 2 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crain Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Millersville
STREET ADDRESS (If rural give location) Crain Highway

3. NAME OF DECEASED (Type or Print) (First) LIZZIE (Middle) B (Last) CARMICHAEL.
4. DATE OF DEATH (Month) Feb (Day) 4 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH May 14, 1865
9. AGE last birthday 83 yrs. — If under 1 year Months Days — If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Annapolis Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George G. Watkins
14. MOTHER'S MAIDEN NAME Mary Jane Phelps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None.
17. INFORMANT Forbus Carmichael, Millersville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) General arterio-sclerosis — unknown

450.0 Antecedent cause(s) (b) Senility — ?

186a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Fracture of condyle of left femur — 2 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
(CITY OR TOWN) Millersville (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) 1/24/49 m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? Fell on floor in dining room - caused by dizziness [5/23/49 (abc)]

22. I hereby certify that I attended the deceased from May, 1948, to 2/3/49, 19....., that I last saw the deceased alive on 2/3/49, 19....., and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE Gustave H. Faulkner M.D. (Degree or title) ADDRESS Glen Burnie, Md DATE SIGNED 2/6/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Feb 7, 1949
NAME OF CEMETERY OR CREMATORY St. Anns
LOCATION (City, town, or county) Annapolis Md (State)
DATE REC'D BY LOCAL REG. 2/7/49
REGISTRAR'S SIGNATURE L. J. DeAlba per T
24. FUNERAL DIRECTOR Thomas W. Singleton
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

RECEIVED
FEB 11 1949
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

334 97 01304

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince George's
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Md. LENGTH OF STAY (in this place) 82 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lanham
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) No address

3. NAME OF DECEASED (Type or Print)	(First) Thomas	(Middle) William	(Last) Contee	4. DATE OF DEATH	(Month) Feb.	(Day) 13,	(Year) 1949
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower	8. DATE OF BIRTH 1883	9. AGE last birthday 65 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Contee		14. MOTHER'S MAIDEN NAME Sarah ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) ---	16. SOCIAL SECURITY NO. unknown	17. INFORMANT Hospital Records					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Arteriosclerosis known to us since 11/24/48

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis

19a. DATE OF OPERATION ---	19b. MAJOR FINDINGS OF OPERATION ---	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify) ----	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ----	(CITY OR TOWN) (COUNTY) (STATE) ------
TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.	INJURY OCCURRED While at Work ☐ Not While ~~At work~~ ☐	HOW DID INJURY OCCUR? ------

22. I hereby certify that I attended the deceased from 11/24, 1948, to 2/13, 1949, that I last saw the deceased alive on 2/13/, 1949, and that death occurred at 4:00 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	February 13, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/16/49	NAME OF CEMETERY OR CREMATORY Mt. ~~Alto~~ Olive Cemetary	LOCATION (City, town, or county) Washington, D. C. (State) Md.
DATE REC'D BY LOCAL REG. 2-14-49	REGISTRAR'S SIGNATURE E. F. Joyce, Local Reg	24. FUNERAL DIRECTOR R. M. Horton Co. Wash DC	ADDRESS 1322 DC St NW

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 16 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

002 13 b

01305

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore
STREET ADDRESS (If rural give location) Annapolis, R 2

3. NAME OF DECEASED (Type or Print) (First) Dorothy (Middle) Marie (Last) Cromwell

4. DATE OF DEATH (Month) Feb. (Day) 19 (Year) 1949

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Aug 11, 1922

9. AGE last birthday 26 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Skidmore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas Cromwell

14. MOTHER'S MAIDEN NAME Ida Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Ida Cromwell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pul. Tuberculoses

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Skidmore (COUNTY) A A (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20, 1948, to 2-19, 1949, that I last saw the deceased alive on 2-17, 1949, and that death occurred at 11:00 A m., from the causes and on the date stated above.

SIGNATURE A. T. Allen (Degree or title) M D ADDRESS 10 Carroll DATE SIGNED 2-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Feb. 23, 1949

NAME OF CEMETERY OR CREMATORY Broadneck

LOCATION (City, town, or county) Skidmore (State) Md

DATE REC'D BY LOCAL REG. Feb. 23, 1949

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR J. B. Johnson, ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

306 Bc 01306 28

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (In this place): 22 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balti. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): none

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William		Davis	2/1/49		19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months / Days	If under 24 hrs. Hours / Min.
male	colored	single	1877	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer	none	Louisiana	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Andrew Brown	Izelle Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yr., give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) General Arteriosclerosis	know to us
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	since 2/17/27
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Cerebral Arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While at Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2/17/27, 19....., to 2/1/49, 19....., that I last saw the deceased alive on 2/1/49, 19....., and that death occurred at 11:55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Marguette M.D. — ADDRESS: Crownsvills, Maryland — DATE SIGNED: 2/2/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2/3/49	Crownsville Hospital	Crownsville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-3-49	E. F. Joyce Local R.	Supt. Hospital	Crownsville Md

RECEIVED
FEB 7 1949
BUREAU V. S.

01307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1
938

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Annapolis
STREET ADDRESS (If rural, give location): 208 Claude St.

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Nelson (Last) Dudley

4. DATE OF DEATH: (Month) 2-24-49 (Day) (Year) 19

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2-24-1903

9. AGE last birthday: 46 yrs. If under 1 year: Months. 0 Days 0 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditour

10b. KIND OF BUSINESS OR INDUSTRY: State of Maryland

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis Dudley

14. MOTHER'S MAIDEN NAME: Mary E. Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Margaret I. Dudley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage.	7 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic cardio-Vascular disease	2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/10, 19 48, to 2/24, 19 49, that I last saw the deceased alive on 2/24, 19 49, and that death occurred at 6 30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Maurice F. Klaware, MD — ADDRESS: 31 South Gate Av, Annapolis Md — DATE SIGNED: 2/24/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Feb. 26, 49 — NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Feb 25 1949 — REGISTRAR'S SIGNATURE: W. J. Brauch

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son Annapolis, Md.

RECEIVED
FEB 26 1949
BUREAU V. S.

01308

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1
186a

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Md — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Deale — LENGTH OF STAY (in this place): Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Deale
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural give location): —

3. NAME OF DECEASED (Type or Print) (First) Maria	(Middle) Ellen	(Last) Ford	4. DATE OF DEATH (Month) Feb	(Day) 7	(Year) 1949		
5. SEX: F.	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Jan 4, 1869	9. AGE last birthday: 80 yrs.	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwf	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME: James Armiger		14. MOTHER'S MAIDEN NAME: — Chambers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: no.	17. INFORMANT: Annie E Hamilton					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Heart Failure — 6 mos

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardiovascular Disease — Unk.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Impacted Colles Fracture - left

19a. DATE OF OPERATION: —	19b. MAJOR FINDINGS OF OPERATION: —	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify): Accident	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home	(CITY OR TOWN): Fell in home Deale	(COUNTY): A.A.	(STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): Jan 31 1949 1:00 A.m.	INJURY OCCURRED While at Work ☐ Not While At work ☑	HOW DID INJURY OCCUR? Tripped while walking in dark		

22. I hereby certify that I attended the deceased from 31 Jan, 1949, to 7 Feb, 1949, that I last saw the deceased alive on 6 Feb, 1949, and that death occurred at 3:30 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Robert B Tasser	MD	Upper Marlboro Md	7 Feb 49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify): Burial	DATE: Feb. 9, 1949	NAME OF CEMETERY OR CREMATORY: St James	LOCATION (City, town, or county) (State): Fraser E. Eles Md
DATE REC'D BY LOCAL REG.: Feb 9th 1949	REGISTRAR'S SIGNATURE: M.P. Clayton Dep. Hall	24. FUNERAL DIRECTOR: D.A. Hardisty Son	ADDRESS: Glenville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
FEB 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01309

331

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH
COUNTY: Anne Arundel Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	J.	Fountain	Feb.	11,	1949

6. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	Colored	Widow	Aug. 31, 1885	63 yrs.	6			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): A.A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Adelaide Gray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: William Fountain

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemmorhage	Feb 10, 1949
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Artery - Selerosis Hypertension	2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb 10, 1949, to Feb 11, 1949, that I last saw the deceased alive on Feb 11, 1949, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. F. Redman Jr.	M.D.	158 - Dey St. Glen Burnie Md.	2/14/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 14, 1949	Franklin Cemetery	Churchton,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 14, 1949	J. B. Dent	J.B. Johnson,	Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 18 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22 — 01310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A.A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups,; LENGTH OF STAY (in this place) 6 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland House of Correction

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) -------

3. NAME OF DECEASED (Type or Print): (First) Karl (Middle) Peter Alvin (Last) Friberg

4. DATE OF DEATH: (Month) Feb. (Day) 8, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 4, 1883

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Stockholm, Sweden

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Amanda Josephine ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: --------

17. INFORMANT: Patient

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Exhaustion, result of extreme Malnutrition — 5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Myocardial degeneration

(c) With edema of the lungs, & general ascites

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: ------

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 3, 1949, to Feb. 8 1949, that I last saw the deceased alive on Feb. 8, 1949, and that death occurred at 5:17 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm A Cook — Physician in Charge - Jessups, Md. — Feb. 9, 1949

23. BURIAL, CREMATION REMOVAL (Specify) | DATE Feb 14 49 | NAME OF CEMETERY OR CREMATORY Cherry Hill | LOCATION (City, town, or county) Jessup | (State) Md

DATE REC'D BY LOCAL REG. Feb 16-49 | REGISTRAR'S SIGNATURE Olaia Harlup

24. FUNERAL DIRECTOR H. L. Collins ADDRESS

RECEIVED
MAR 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01311

FILM No. G 119 APR 13 1949

CERTIFICATE OF DEATH

331
83a

Reg. Dist. No. 24

1. PLACE OF DEATH: COUNTY a. a. co MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE | COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) (Last) Galloway

4. DATE OF DEATH (Month) 2 (Day) 1 (Year) 1949

5. SEX female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow | 8. DATE OF BIRTH Nov 28 1879 | 9. AGE last birthday 70 yrs. | If under 1 year Months. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | 10b. KIND OF BUSINESS OR INDUSTRY none | 11. BIRTHPLACE (State or foreign country) a. a. County | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage E.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis generalized

(c)

INTERVAL BETWEEN ONSET AND DEATH 6 days.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 26, 1949, to 2-1, 1949, that I last saw the deceased alive on 2-1, 1949, and that death occurred at 11.20 A m., from the causes and on the date stated above.

SIGNATURE E. Rumbaugh. (Degree or title) MD. ADDRESS Earnport Md DATE SIGNED 2/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Friday 4-49 | NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. | LOCATION (City, town, or county) Brooklyn Md (State)

DATE REC'D BY LOCAL REG. 2/4/49 | REGISTRAR'S SIGNATURE A. W. Hedrick Dm | 24. FUNERAL DIRECTOR Elroy D. Wilson ADDRESS 1000 Brantly Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

443
93d

01312

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 53 Larkins Street	STREET ADDRESS (If rural give location) 53 Larkins Street

3. NAME OF DECEASED (Type or Print)	(First) George	(Middle)	(Last) Goodin	4. DATE OF DEATH	(Month) 2-	(Day) 11-	(Year) 1949
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1885	9. AGE last birthday 63 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Annapolis, A.A.Co. Md.	12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME Edward Goodin	14. MOTHER'S MAIDEN NAME Georgianna Whipple						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Paul Gilchrist					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	sudden
Antecedent cause(s)	(b) Chronic myocarditis	unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertensive Cardio-vascular disease	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from made a Postmortem Examination, 19..., to Feby. 11, 1949, ~~that I last saw the deceased alive on ....., 19....~~, and that death occurred at 8 30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Claffy, M.D.,	Deputy Medical Examiner,	Annapolis Maryland	2-14-49.

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2-14-1949	NAME OF CEMETERY OR CREMATORY Asbury	LOCATION (City, town, or county) (State) Smithville St. Annapolis, Md.
DATE REC'D BY LOCAL REG. Feb. 14, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mrs. Charles E. Hicks-	ADDRESS 43-45 Northwest St.

RECEIVED
FEB 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Vol 43 776 159

01313

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort Geo G. Meade

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs 32 min

Hospital, Institution, or street address where death occurred:

Station Hospital Ft Geo G. Meade, Md.

How long in hospital or institution? 4 hrs 32 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Texas County: Travis

City or town: Austin ✓

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pikesville Armory, Md.

(If rurol, give LOCATION)

2.(a) If veteran, name war: Balto. Co.

3.(a) FULL NAME: GUNN BABY BOY (Twin) 1st

3.(b) Social Security Number: * *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	- -

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 9, 1949 1213 hrs

8. AGE: Years	Months	Days	If less than one day
			4 hrs. 32 min.

9. Birthplace: Ft Geo G Meade A.A. Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Lorain A. Gunn

13. Birthplace: Austin, Texas

MOTHER 14. Maiden name: Erma K. West

15. Birthplace: Austin, Texas

16. Informant: Lorain A. Gunn

Address: 2501 ASU Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10 49 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Ft Geo G Meade, Md.

18. Funeral director: Capt Harmon D. Moore (Chap USA)

Address: Ft Geo G Meade, Md.

19. 14 Feb 49 (Date rec'd by registrar) E.K. BURNSIDE, CAPT MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 February 19 49 at 1645 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1213 hrs 9 February 19 49 to 1645 hrs 9 Feb 19 49 and that I last saw him alive on 9 February 19 49

Immediate cause of death: Premature birth — DURATION

6½ months gestation.

Due to:

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry M. Foster

HENRY M. FOSTER, CAPT., M. D. or other MC

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
FEB 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

2nd CB 776 159

01314

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft Geo G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 hrs 28 min

Hospital, Institution, or street address where death occurred:
Station Hospital Ft Geo G. Meade, Md.

How long in hospital or institution? 5 hrs 28 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Texas County: Travis

City or town: Austin
(If outside city or town limits, write RURAL and give nearest town)

Street No. Pikeville Armory Md
(If rural, give LOCATION)

2.(a) If veteran, name war: Balt Co.

3.(a) FULL NAME: GUNN BABY BOY (Twin) 2nd

3.(b) Social Security Number: - -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	- -

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 9, 1949 1217 hrs

8. AGE: Years	Months	Days	If less than one day
			5 hrs. 28 min.

9. Birthplace: Ft Geo G Meade AA Md
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Lorain A. Gunn
13. Birthplace: Austin, Texas.

MOTHER
14. Maiden name: Erma K. West
15. Birthplace: Austin, Texas.

16. Informant: Lorain A. Gunn
Address: 2501 ASU Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10 49 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Ft Geo G. Meade, Md.

18. Funeral director: Capt Harmon D. Moore (Chap USA)
Address: Ft Geo G. Meade, Md.

19. 14 Feb 19 49 (Date rec'd by registrar) E.K. Burnside
E.K. BURNSIDE, CAPT MC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 February 19 49 at 1745 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1217 hrs 9 February 19 49, to 1745 hrs 9 Feb 49 and that I last saw him alive on 9 February 19 49

Immediate cause of death	DURATION
Premature birth.	
6½ months gestation	
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Foster
HENRY M. FOSTER, CAPT., M. D. or other MC

Address: Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Pub
242

RECEIVED
FEB 16 1949
BUREAU F. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01315

002

13b

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 11 mos. 16 da.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bowie
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) unknown

3. NAME OF DECEASED (Type or Print)	(First) Mary	(Middle)	(Last) Hall	4. DATE OF DEATH	(Month) 2/25/49 (Day) (Year) 19
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH unknown ABT 1892	9. AGE last birthday 57(?) yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) unknown	12. CITIZEN OF WHAT COUNTRY? unknown		
13. FATHER'S NAME unknown	14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculosis of Lungs	known to us
Antecedent cause(s)		since 2/22/49
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) General Paresis	known since 3/9/48

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/9/48, 19....., to 2/25/49, 19....., that I last saw the deceased alive on 2/25/49, 19....., and that death occurred at 2:45 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	2/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Mar. 1, 1949	NAME OF CEMETERY OR CREMATORY Century Cem.	LOCATION (City, town, or county) Bowie (State) Md.
DATE REC'D BY LOCAL REG. Feb. 28, 1949	REGISTRAR'S SIGNATURE E. F. Joyce L-Reg	24. FUNERAL DIRECTOR J. B. Johnson	ADDRESS Annapolis

RECEIVED
MAR 4 1949
BUREAU V. S.

1949
C7
1877

MARYLAND STATE DEPARTMENT OF HEALTH

01316

2411 N. Charles Street, Baltimore 444

CERTIFICATE OF DEATH 102

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold, near Annapolis
LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Arnold near Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold near Annapolis
STREET ADDRESS (If rural, give location) Arnold near Annapolis

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) ------ (Last) Holoand

4. DATE OF DEATH: (Month) 2 - (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7-5 -1876

9. AGE last birthday: 72 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Johnson

14. MOTHER'S MAIDEN NAME: Mary Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT: Lillian Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Encephalopathy 8 m

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) Arnold (COUNTY) (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-21 1949, to 2-24 1949, that I last saw the deceased alive on 2-21 1949, and that death occurred at 5 A m., from the causes and on the date stated above.

SIGNATURE O. T. Allen (Degree or title) M D ADDRESS 10 Conrad DATE SIGNED 2-25-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2- 27- 1949
NAME OF CEMETERY OR CREMATORY Mt. Calvary
LOCATION (City, town, or county) (State) Arnold, Md. near Annapolis

DATE REC'D BY LOCAL REG. Feb 25 1949
REGISTRAR'S SIGNATURE W. T. Branch

24. FUNERAL DIRECTOR Mrs. Charles E. Hicks- ADDRESS 43-45 Northwest St.

RECEIVED
MAR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

155 01317

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annap olis
LENGTH OF STAY (in this place): 36 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 43 Larkins Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 43 Larkins Street

3. NAME OF DECEASED (Type or Print): (First) Louise (Middle) Brown (Last) Johnson

4. DATE OF DEATH: (Month) 2- (Day) 3- (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 3-2-1899

9. AGE last birthday: 49 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Arnold, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elijah Brown

14. MOTHER'S MAIDEN NAME: Mary Jane Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service): Non

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Franklin D. Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Malnutrition

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Metastases of Carcinoma to vital organs

(c) Carcinoma of gallbladder.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-7-48

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of gallbladder with metastases

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN): Annapolis (COUNTY): Ca (STATE): and

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-25, 1948, to 2-4, 1949, that I last saw the deceased alive on 2-2, 1949, and that death occurred at 8:10 A m., from the causes and on the date stated above.

SIGNATURE: E. T. Allen (Degree or title): MD ADDRESS: 10 Carroll DATE SIGNED: 2-5-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 2-8-1949
NAME OF CEMETERY OR CREMATORY: Mt. Calvary
LOCATION (City, town, or county) (State): Arnold, Maryland

DATE REC'D BY LOCAL REG.: Feb. 7, 1949
REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks
ADDRESS: 43-45 Northwest St.

RECEIVED
FEB 11 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01318

443
93d

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis; LENGTH OF STAY (in this place): Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis; STREET ADDRESS (If rural, give location): 914 Spa Road

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) HENRY (Last) JOHNSON

4. DATE OF DEATH: (Month) 2- (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 9- 21-1888

9. AGE last birthday: 60 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Anne Arundel Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 214- 05-1344

17. INFORMANT: Samuel Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 2 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio-Vascular Disease — 4 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-8-, 1949, to 2-9-, 1949, that I last saw the deceased alive on 2-9-, 1949, and that death occurred at 7 15 P m., from the causes and on the date stated above.

SIGNATURE: James R. Stanton (Degree or title): M.D. ADDRESS: Annapolis, Md. DATE SIGNED: 2/11/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 2-13-1949 — NAME OF CEMETERY OR CREMATORY: Fowlers Chapel Cemetery — LOCATION (City, town, or county) (State): Best Gate, A.A.Co. Md.

DATE REC'D BY LOCAL REG.: Feb. 14, 1949 — REGISTRAR'S SIGNATURE: [illegible] D. Brinch

24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks — ADDRESS: 43-45 Northwest St.

RECEIVED
FEB 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2 Bc 01319
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 218

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 11 mo. 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural give location): None

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) (Last) Jones

4. DATE OF DEATH: (Month) 2 (Day) 18th. (Year) 1949

5. SEX: female

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH: Abt. 1872 (not known)

9. AGE last birthday: 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myodegeneratio Cordis — known to us since 2/24/48

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis — known to us since 2/24/48

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/24/48, 19..... to 2/18....., 1949, that I last saw the deceased alive on 2/18, 1949, and that death occurred at 6:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Marguette M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 2/18/49

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE: 2-22-49 — NAME OF CEMETERY OR CREMATORY: Mt Auburn — LOCATION (City, town, or county) (State): Balto. Md.

DATE RECD BY LOCAL REG.: 2-20-49 — REGISTRAR'S SIGNATURE: Sr. Joyce Lord

24. FUNERAL DIRECTOR: Wm. Francis A. Hinckley — ADDRESS: 2111 N. [illegible] St.

VS. A15

1949
77
1872

RECEIVED
FEB 22 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01320

2411 N. Charles Street, Baltimore

331

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY MAYO, A.A.CO. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MAYO. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
	STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANNIE	L.	JOYCE	FEB	8	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	C.	W	APR. 1883	66 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WORK		MAYO. MD.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
UNKNOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	NO	SOLOMON NICHOLS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemmhage.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) hypertension, arteriosclerosis.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 4, 1949, to Feb. 8, 1949, that I last saw the deceased alive on Feb 6, 1949, and that death occurred at 1 m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Emily H. Nilson, M.D.		2/10/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY ~~OR CREMATORY~~	LOCATION (City, town, or county)	(State)
	Feb 10-1949	ST. MARKS	MAYO. A.A.CO	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 10, 1949	Edward Collemon	T.A. HARDESTY & SON	GALESVILLE MD.

VS. A15

RECEIVED
FEB 16 1949
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

420.1 94a 01321

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne ARUNDEL
City or town: ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
EMERGENCY HOSPITAL
How long in hospital or institution? 23 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: A.A.
City or town: SUDLEY
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: ELLEN MARIE KATSKI

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of husband or wife: HAROLD KATSKI
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): AUG. 30, 1887

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: HARTFORD, CONN.
(Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant: HAROLD KATSKI
Address: SUDLEY, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof FEB. 10, 1949 (month) (day) (year)
Cemetery or crematory: CATHOLIC CEMETERY
Location: OWENSVILLE, MD.

18. Funeral director: T. A. HARDESTY & SON
Address: GALESVILLE, MD.

19. Feb. 9 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 8 1949, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1948, to Feb 8 1949 and that I last saw h. alive on Feb 8 1949

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Generalized Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of Injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Evergreen Rd. Date signed 2/9/49.

RECEIVED
FEB 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 01322
73d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester
STREET ADDRESS (If rural, give location) R. 7 D. Annapolis Md

3. NAME OF DECEASED (Type or Print): (First) GENEVA (Middle) HALL (Last) KEMP

4. DATE OF DEATH: (Month) 2 (Day) 26 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH: 4-4-1888

9. AGE last birthday: 60 yrs. If under 1 year: Months. 10 Days 22 If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel L. Hall

14. MOTHER'S MAIDEN NAME: Mary A. Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT: Mrs Frank H. McDonald

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary thrombosis	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis chr	1 yea
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 26, 1949, to Feb 26 (1 hr.) 1949, that I last saw the deceased alive on Feb. 26, 1949, and that death occurred at 10 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C. Bond M D. Annapolis Md. 2-27-49

23. ~~BURIAL~~, CREMATION, ~~REMOVAL~~ (Specify) | DATE Mar 1 1949 | NAME OF CEMETERY OR CREMATORY Green Mount | LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REG. Feb. 28, 1949 | REGISTRAR'S SIGNATURE J. Enoch | 24. FUNERAL DIRECTOR ADDRESS JOHN M. TAYLOR & SON ANNAPOLIS MD

RECEIVED
MAR 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01323

420.1
932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 N. Cherry Grove Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
STREET ADDRESS (If rural, give location) 1 N. Cherry Grove Ave

3. NAME OF DECEASED (Type or Print) (First) ISABELLA (Middle) ANDERSON (Last) SHANKS KNUDSEN

4. DATE OF DEATH (Month) 2 (Day) 10 (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 8-12-1876

9. AGE last birthday 72 yrs. If under 1 year: Months 5, Days 20. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Leith Scotland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Archibald Shanks

14. MOTHER'S MAIDEN NAME Elizabeth Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) —

16. SOCIAL SECURITY NO. —No

17. INFORMANT W. M. Mebane

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardiorespiratory failure	48 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) coronary occlusion	2 mos.
	(c) Arteriosclerotic cardiovascular disease	15 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 2, 1947, to Feb. 10, 1949, that I last saw the deceased alive on Feb. 9, 1949, and that death occurred at 9:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) E. Peyton Ritchie, M.D. — ADDRESS Annapolis, Md. — DATE SIGNED Feb 11 1949

23. ~~BURIAL~~, CREMATION, REMOVAL (Specify) — DATE 2-11-49 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State) Hendersonville N.C.

DATE REC'D BY LOCAL REG. Feb. 11, 1949 — REGISTRAR'S SIGNATURE W. J. Bunch

24. FUNERAL DIRECTOR — ADDRESS John M. Taylor & Son Annapolis Md.

RECEIVED
FEB 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

753.1 84a 01324

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural, Laurel
LENGTH OF STAY (In this place): 19 years +
HOSPITAL OR INSTITUTION OR STREET ADDRESS: District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Washington — COUNTY: D.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Washington
STREET ADDRESS (If rural give location): 1706 Seaton St. N.W.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Louise	Virginia	Lomax	Feb	5	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Mln.
F	Negro	single	June 5, 1922	26 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none	none	Virginia	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Lomax	Emma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO		—	D. T. S. Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) spastic quadriplegia with convulsions since birth

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. idiocy since birth

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct, 1946, to Feb 5, 1949, that I last saw the deceased alive on Feb 5, 1949, and that death occurred at 6:05 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. A. Alston, MD		District Training School Laurel	Feb 5/1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY, OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb 7-49	District Training School	Laurel	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 7-49	Clara Haslup		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 10 1949
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

421.4 92d 01325

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

1. PLACE OF DEATH
COUNTY A.A. County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shore Acres, Arnold, Md. | LENGTH OF STAY (in this place) 2mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural, give location) Shore Acres

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) (Last) LONG

4. DATE OF DEATH (Month) Feb. (Day) 12, (Year) 1949

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH Sept. 20, 1875 | 9. AGE last birthday 73 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Long

14. MOTHER'S MAIDEN NAME Elizabeth Weis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT Miss Virginia Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: 3 months

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chronic Valvular Disease ? Auricular fibrillation ?

(c) Influenza - Was recovering & was afebrile for 4 days.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/1, 1949, to 2/12, 1949, that I last saw the deceased alive on 2/8, 1949 and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Maurice F. Klaware, MD 31 Southgate Av. Annapolis, Md 2/12/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 2/15/49 | NAME OF CEMETERY OR CREMATORY Mt. Carmel | LOCATION (City, town, or county) Baltimore, (State) d.

DATE REC'D BY LOCAL REG. 2/15/49 | REGISTRAR'S SIGNATURE A. W. Hedrick DR

24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. ADDRESS BALTIMORE - 13, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 01326
61

CERTIFICATE OF DEATH

Reg. Dist. No. 5-1

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
MARYLAND
LENGTH OF STAY (in this place) 3 Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE
COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 1032 Thomas Rd. Glen Burnie Md. Anne A
STREET ADDRESS (If rural give location) 1032 Thomas Rd.

3. NAME OF DECEASED (Type or Print) (First) Josephine (Middle) V. (Last) Long

4. DATE OF DEATH (Month) Feb. (Day) 1st (Year) 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH March 18 1880

9. AGE last birthday 68 yrs. If under 1 year Months 10 Days 13 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Kingston N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph Trenkle

14. MOTHER'S MAIDEN NAME Helen ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Edward Josepg Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CORONARY ARTERIOSCLEROSIS

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) UNKNOWN

(c) GENERALIZED ARTERIOSCLEROSIS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. DIABETES MELLITUS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ., 1948, to Jan ., 1949, that I last saw the deceased alive on Jan 25, 1949, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Henry J Langan MD

ADDRESS 201 W. Annapolis Blvd

DATE SIGNED Glen Burnie Feb, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Feb. 4th 1949

NAME OF CEMETERY OR CREMATORY Green Wood Cemetery

LOCATION (City, town, or county) (State) Brooklin New York

DATE REC'D BY LOCAL REG. 2/2/49

REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR Frank Della Noce

ADDRESS 322 S. High St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01327

692.4

152

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural give location) Woodland Beach

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) E. (Last) Martz
4. DATE OF DEATH: (Month) Feby (Day) 3 (Year) 19

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Abt. 1888
9. AGE last birthday: 61 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoper
10b. KIND OF BUSINESS OR INDUSTRY: Sea food.
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-30-2711
17. INFORMANT: A. A. Co. Police

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Septicemia	unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cellulitis of right leg + thigh	unknown
	(c) Infected area on right thigh	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination on July 3, 1949, ~~that I last saw the deceased alive on~~ ~~19~~, and that death occurred at 5 15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Claffy M.D. Deputy Medical Examiner Annapolis Md 2-3-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 2/4/49
NAME OF CEMETERY OR CREMATORY AA County Home
LOCATION (City, town, or county) (State) Edgewater, Md.

DATE REC'D BY LOCAL REG. Feb. 4, 1949
REGISTRAR'S SIGNATURE Edward Collenson
24. FUNERAL DIRECTOR T H Hardesty & Son
ADDRESS Gibsville Md

RECEIVED
FEB 8 1949
BUREAU V. S.

1949
61
1888

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1
93d

01328

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arundel on Bay nr Annapolis
LENGTH OF STAY (in this place): 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Arundel on Bay R. F. D.#3

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A. CO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Arundel on Bay N. Annapolis
STREET ADDRESS (If rural, give location): R.F. D #3 Arundel on Bay

3. NAME OF DECEASED (Type or Print) (First) Julia (Middle) (Last) McEwen

4. DATE OF DEATH (Month) 2-20 (Day) (Year) 19

5. SEX: Female

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Feb 1857 0-49

9. AGE last birthday: 92 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joe Beaford

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Harriet Wilkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Arterio-Sclerosis — 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1948, to Feb 20, 1949, that I last saw the deceased alive on Feb 20, 1949, and that death occurred at 6:30 A m., from the causes and on the date stated above.

SIGNATURE: R. F. Richardson — (Degree or title): M.D. — ADDRESS: Annapolis, Md. — DATE SIGNED: 2/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: — NAME OF CEMETERY OR CREMATORY: Ship to Oxford Miss — LOCATION (City, town, or county) (State): Oxford Mississippi

DATE REC'D BY LOCAL REG.: Feb 22, 1949 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: Mrs Ethel L. Hicks — ADDRESS: 45 Northwest st Annapolis Md.

RECEIVED
FEB 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01329

422.1
932

CERTIFICATE OF DEATH

Reg. Dist. No. 2-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RIVIERA BEACH (PASADENA MD) — LENGTH OF STAY (in this place): 6/12 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: CAYVOLL ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Riviera Beach (Pasadena Md. P.O.)
STREET ADDRESS (If rural give location): CARROLL Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
ANNA	MATILDA	MILLER.	FEBRUARY 18 1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	WHITE	WIDOWED	FEB. 15 1862	87 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	OWN HOME.	JENNERS TOWNSHIP, SOMERSET. CO. PA.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
NOAH GOHN.	ELIZABETH LUDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
NO	NONE	MRS. ROSE STERN, Riviera Beach, Pasadena, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart Failure	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerotic Cardio-Vascular Disease	20 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb. 10, 1949, to Feb. 18, 1949, that I last saw the deceased alive on Feb. 17, 1949, and that death occurred at 1:50 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Brady Smith, M.D.		Riviera Beach, Md.	2/18/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Ship to Rockwood Pa.		JENNERS Cross Road	JENNERS Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2/18/49	L. J. DeAlba	Thomas W. Singleton	

RECEIVED
FEB 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

500 110 b 01330 Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 72 Washington St	STREET ADDRESS (If rural, give location) 72 Washington

3. NAME OF DECEASED (Type or Print)	(First) WARDELL	(Middle)	(Last) MOWBRAY	4. DATE OF DEATH	(Month) FEBY.	(Day) 5	(Year) 1949
5. SEX MALE	6. COLOR OR RACE NEGRO	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH OCT. 21. 1903	9. AGE last birthday 46 yrs.	If under 1 year Months. Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boot-black	10b. KIND OF BUSINESS OR INDUSTRY BOOT-BLACK STAND	11. BIRTHPLACE (State or foreign country) Annapolis	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Albert Mobray	14. MOTHER'S MAIDEN NAME Susie Mobray						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Susie Mobray					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Broncho - pneumonia	4 days
Antecedent cause(s)	(b) Acute Bronchitis	2 weeks
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Acute Pleurisy	4 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended the deceased from~~ made a Postmortem Examination Feby 5, 1949, ~~that I last saw the deceased alive on~~ ~~19~~, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Caffey M.D.	Deputy Medical Examiner	Annapolis Maryland	2-9-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2-8-49	NAME OF CEMETERY OR CREMATORY Brewer Hill	LOCATION (City, town, or county) Annapolis - AA	(State) Md.
DATE REC'D BY LOCAL REG. Feb. 9, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR William Reese II	ADDRESS	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS. A15

RECEIVED
FEB 11 1949
BUREAU V. S.

01331

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

450.1

61

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH
COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Lothian
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Lothian,
STREET ADDRESS (If rural give location) 2½ miles - SW Lothian Md

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) Elizabeth (Last) Moreland

4. DATE OF DEATH: (Month) Feb (Day) 20 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 12 Jan 1874

9. AGE last birthday: 75 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Cahn

14. MOTHER'S MAIDEN NAME: Edith Virginia Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: J. Oden Moreland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cachexia	3 mos
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arteriosclerosis	10 years
	(c) Diabetes & gangrenous foot left	8 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 19 46, to 20 Feb, 19 49, that I last saw the deceased alive on 20 Feb, 19 49, and that death occurred at 3.50 P m., from the causes and on the date stated above.

SIGNATURE: R B Travers — (Degree or title) M D — ADDRESS: Upper Marlboro, Md — DATE SIGNED: 20 Feb 49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-22-49 — NAME OF CEMETERY OR CREMATORY: Mt Zion Methodist — LOCATION (City, town, or county) (State): Mt Zion, Md.

DATE REC'D BY LOCAL REG. 2/21/49 — REGISTRAR'S SIGNATURE: M. M. Clayton

24. FUNERAL DIRECTOR — ADDRESS: B. L. Hopping and Son

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 24 1949
BUREAU U. S.

M

01332

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

722.0

CERTIFICATE OF DEATH

59a Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patuxent
LENGTH OF STAY (in this place) 77 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patuxent (Odenton P.O. Md)
STREET ADDRESS (If rural give location) —

3. NAME OF DECEASED (Type or Print) (First) Laura (Middle) Neary (Last)

4. DATE OF DEATH (Month) Feb. (Day) 27 (Year) 1949

5. SEX Female
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 24, 1885
9. AGE last birthday 63 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Housewife)
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Laurel, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John E. Whitehead
14. MOTHER'S MAIDEN NAME Mary Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT Harry Neary, Odenton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute Cardiac Failure suddenly

Antecedent cause(s) (b) Chronic Rheumatoid Osteoarthritis 6 yrs

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) —
TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 12-1-48, 19....., to 2-27-49, 19....., that I last saw the deceased alive on 2-25-49, 19....., and that death occurred at 10 A. m., from the causes and on the date stated above.

SIGNATURE Joseph Lipskey (Degree or title) ADDRESS Odenton Md DATE SIGNED 2-28-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE MAR. 1-1949
NAME OF CEMETERY OR CREMATORY Trinity Ch. yard
LOCATION (City, town, or county) (State) Patuxent, (Odenton P.O. Md)
DATE REC'D BY LOCAL REG. 2/28/49
REGISTRAR'S SIGNATURE L. J. De Alba
24. FUNERAL DIRECTOR Thomas W Singleton ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

RECEIVED
MAR 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

01333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 4 yr. 7 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balt. City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City; STREET ADDRESS (If rural, give location) 913 Shuter Street

3. NAME OF DECEASED (Type or Print): (First) Rosa; (Middle) L.; (Last) Peterson

4. DATE OF DEATH: (Month) 2/22/49; (Day); (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 1887

9. AGE last birthday: 61 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY? ??

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Arteriosclerosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH: known to us since 2/16/45

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐:

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/16/45, 19....., to 2/22/49, 19....., that I last saw the deceased alive on 2/22/49, 19....., and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Rumpenstein M.D.

ADDRESS: Crownsville, Maryland

DATE SIGNED: 2/23/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 2/26/49

NAME OF CEMETERY OR CREMATORY: Mt. Calvary

LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG. 2/25/49

REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Elgar Wilson

ADDRESS: Baltimore, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH Be 01335

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH 331 838 Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: a. a. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park | LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedar Crest Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Balto. City
STREET ADDRESS (If rural, give location): 2133 Jefferson St

3. NAME OF DECEASED (Type or Print): (First) Estelle (Middle) (Last) Schriver
4. DATE OF DEATH: (Month) Feb (Day) 5th (Year) 1949

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 10/24/1873
9. AGE last birthday: 75 yrs. | If under 1 year: Months. 3 | Days 11 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas E. Ward
14. MOTHER'S MAIDEN NAME: Anna Euler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hilda M. Johnson 6425 Old Washington Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: ?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — ?

(c) Senility — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED White at Work ☐ Not White At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15, 1948, to 2/4, 1949, that I last saw the deceased alive on 2/4, 1949, and that death occurred at 7.30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Gustave H. Paulsen M.D. | 5 Fairfax Ave S.E. - Glen Burnie, Md. | 2/7/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 2/8/49 | NAME OF CEMETERY OR CREMATORY: London Park | LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG. 2/7/49 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: Wm Cook Inc. | ADDRESS: 1217 St. Paul St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

450.0 92 b

01334

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessups
LENGTH OF STAY (in this place) 57 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Md. House Correction

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) Hill Street

3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Short

4. DATE OF DEATH (Month) Feb. (Day) 18, (Year) 1949

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH unknown

9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor

10b. KIND OF BUSINESS OR INDUSTRY Laborer

11. BIRTHPLACE (State or foreign country) Maryland (Charles County)

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Patient

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive heart failure — 57 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Valvular heart disease (mitral & aortic)

(c) Arterio-sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ----

19b. MAJOR FINDINGS OF OPERATION ---------

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ----

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----

(CITY OR TOWN) (COUNTY) (STATE) ------

TIME OF INJURY (Month) (Day) (Year) (Hour) ---- m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? -----

22. I hereby certify that I attended the deceased from Dec. 24, 1948, to Feb. 18, 1949, that I last saw the deceased alive on Feb. 17, 1949, and that death occurred at 7:05A m., from the causes and on the date stated above.

SIGNATURE John A. Clark (Degree or title) ADDRESS DATE SIGNED

John A. Clark, M.D., Physician in Charge, MHC - Jessups, Md. Feb. 18, 1949

23. BURIAL, CREMATION REMOVAL (Specify) DATE Feb 24-49 NAME OF CEMETERY OR CREMATORY Cherry Hill LOCATION (City, town or county) Jessup (State) Md

DATE REC'D BY LOCAL REG. Feb 23-49 REGISTRAR'S SIGNATURE Clara Hashep

24. FUNERAL DIRECTOR Harry L. Collins ADDRESS Jessup Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 7 1949
BUREAU V. S.

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01336

420.1
94a

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Raynor Heights
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

~~Hospital, institution, or~~ street address where death occurred: Evelyn Ave. & Franklin

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Raynor Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Evelyn Ave & Franklin
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Barbara Katie Snaut

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: C. John Snaut

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 3, 1860

8. AGE: Years: 88 Months: 9 Days: — If less than one day: ..... hrs. ..... min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Hoffman
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. George Snyder

Address: Evelyn Ave & Franklin, Raynor Heights

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 2-5-49 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Baltimore, Maryland

18. Funeral director: George L. Schwab

Address: 2101 Frederick Ave. Balto., Md.

19. 2/4 1949 Alo. Hedrick Dr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3, 1949, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1949, to Feb 3, 1949 and that I last saw h. ~~[illegible]~~ alive on Feb 2 1949

Immediate cause of death: Coronary Thrombosis — DURATION: 2 weeks

Due to: Generalized Arteriosclerosis — 2 years

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 1001 Annapolis Rd. Date signed: 4/3/49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01337

331
83a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.N.H. Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severna Park
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Elvis	Marion	SNOW		February	1	1949

5. SEX	6. COLOR OR RACE	7. MARRIED, ~~WIDOWED, DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male.	White.		9-7-97	51 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy.
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E.M. SNOW
14. MOTHER'S MAIDEN NAME: Marie SUSKY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If year, give war or dates of service): WW I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Hemorrhage, Cerebral.	10 Days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension, Arterial.	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
- - - - - - - -	- - - - - - - - - - - - - - - - - - - -	Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
- - - - - -	- - -	- - - - - - - - - - - - - - - - - - -

RECEIVED
FEB 3 1949
BUREAU V. S.

Rc 01338

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3533
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 3 years, 3mos	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural give location) 304 N. Carey Street

3. NAME OF DECEASED (Type or Print) (First) Rosie	(Middle)	(Last) Tate	4. DATE OF DEATH (Month) 2/	(Day) 15/49	(Year) 19
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 1876	9. AGE last birthday 73 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Henry Rogers		14. MOTHER'S MAIDEN NAME Emma West			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myodegeneratio Cordis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Organic Brain Disease

(c) Epilepsy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: known to us since 11/3/45

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/3/45, 19....., to 2/15/49, 19....., that I last saw the deceased alive on 2/15/49, 19....., and that death occurred at 12:05 m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville, Maryland	2/15/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 2/18/49	NAME OF CEMETERY OR CREMATORY Mt. Auburn	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG. 2/16/49	REGISTRAR'S SIGNATURE E. F. Joyce Lorne R.	24. FUNERAL DIRECTOR (Mrs) Katie R. Williams	ADDRESS 3227 Schroeder St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

002 13-b Be 01339

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Balt. City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 2 ys. 4 mos.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural give location): none

3. NAME OF DECEASED (Type or Print) (First) James (Middle) (Last) Thomas			4. DATE OF DEATH (Month) 2/5/49 (Day) (Year) 19		
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 1910	9. AGE last birthday: 39 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: William Thomas		14. MOTHER'S MAIDEN NAME: Annie Hawkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculosis of the Lungs	known to us since 1/7/49
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Convulsive Disorders (Epilepsy)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/7/46, 19....., to 2/5/49, 19....., that I last saw the deceased alive on 2/9/49, 19....., and that death occurred at 6:00 A. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) ADDRESS: Crownsville, Maryland DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Buried	DATE: 2/15/49	NAME OF CEMETERY OR CREMATORY: Mt. Calvary	LOCATION (City, town, or county) (State): Anne Arundel Co. Md.
DATE REC'D BY LOCAL REG.: 2/15/49	REGISTRAR'S SIGNATURE: A. W. Hedrick Jr.	24. FUNERAL DIRECTOR: Mrs Katie R Williams	ADDRESS: 322 N Schroeder St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

331 01340

83a

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Dorchester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): since 6/9/43	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): East New Market, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Clara (Middle) (Last) Thompson			4. DATE OF DEATH (Month) February (Day) 26 (Year) 1949		
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH: 1877	9. AGE last birthday: 72 yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework	10b. KIND OF BUSINESS OR INDUSTRY: ----		11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Levin Jackson ?			14. MOTHER'S MAIDEN NAME: Angeline Jackson nee Matthews		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: Unknown		17. INFORMANT: Hospital records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 9, 1943, to Feb. 26, 1949, that I last saw the deceased alive on Feb. 25, 1949, and that death occurred at 9:20P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob Morgenstern M.D

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: March 2 1949	NAME OF CEMETERY OR CREMATORY: East new market	LOCATION (City, town, or county) (State): East new market md.
DATE REC'D BY LOCAL REG. 2/26.49	REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg.	24. FUNERAL DIRECTOR: J J Frampton Sen. Federalsburg	ADDRESS: md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

RECEIVED
MAR 1 1949
BUREAU V. S.

Dr. Richardson

056.1 01341

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

9 Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural, give location) Churchton

3. NAME OF DECEASED (Type or Print): (First) Rylend (Middle) R. (Last) Tyler
4. DATE OF DEATH: (Month) Feb. (Day) 23 (Year) 19 49
5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single
8. DATE OF BIRTH: Aug. 3 1948
9. AGE last birthday: ___ yrs. If under 1 year: Months 6 Days | If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Churchton Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Nickleson (NICKLE ON BIRTH)
14. MOTHER'S MAIDEN NAME: Irene Tyler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Irene Tyler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchy. Pneumonia.	Feb 19, 1949
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Whooping Cough.	Jan 27, 1949
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While at Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 28th 49, to Feb 23, 49, that I last saw the deceased alive on Feb 23, 49, and that death occurred at 4:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R. B. Richardson M.D. Annapolis 2/24/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State)

Burial Feb. 25/49 Arrington Churchton Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

Feb. 25, 1949 D. B. Dent Jr. J. B. Johnson Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 4 1949
BUREAU V. S.

01342

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 154 CONDOIT

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD | COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
STREET ADDRESS (If rural, give location) 154 CONDUIT

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	S	VANSANT Sr.	2	17	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE		10-17-1874	74 yrs.	4			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. U.S NAVAL ACADEMY
10b. KIND OF BUSINESS OR INDUSTRY RET.
11. BIRTHPLACE (State or foreign country) ANNAPOLIS MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES H VANSANT
14. MOTHER'S MAIDEN NAME MARY E. KIMBALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT JAMES S. VANSANT JR.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteriosclerosis	10 yrs
	(c) Hypertension	10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1938, to Feb 17, 1949, that I last saw the deceased alive on Feb 17, 1949, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C Bovil		Annapolis MD	2-18-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2-19-49	St MARGARETS	St MARGARETS A.A.Co MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 19, 1949	[signature]	JOHN M. TAYLOR & SON	ANNAPOLIS MD

VS. A15

RECEIVED
FEB 22 1949
BUREAU V. S.

01343

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.0
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 25 Days.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mrs. Wilsons Nursing Home.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Patuxent
STREET ADDRESS (If rural give location) Odenton Road.

3. NAME OF DECEASED (Type or Print): (First) FRANK (Middle) VOLKMER. (Last)

4. DATE OF DEATH (Month) FEB. (Day) 25 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Age 1861

9. AGE last birthday: About 88 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired.

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service) —

16. SOCIAL SECURITY No.: None

17. INFORMANT: A.D. Riden, Patuxent, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arterio-sclerotic Heart Disease — 3 Mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec ....., 19 49, to Feb 25, 19 49, that I last saw the deceased alive on Feb 24, 19 49, and that death occurred at 2:30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edward J Merritt M.D. Gambrills Md Feb 27, 49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE Feb. 28, 1949 — NAME OF CEMETERY OR CREMATORY Trinity, Patuxent Md. — LOCATION (City, town, or county) (State) Patuxent Md.

DATE REC'D BY LOCAL REG. 2/28/49 — REGISTRAR'S SIGNATURE L. J. D'Alba — 24. FUNERAL DIRECTOR Thomas W. Singleton — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 1 1949
BUREAU V. S.

1949
S
1961

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

450.0 Bc 01344

CERTIFICATE OF DEATH

97

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Cedar Crest Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 803 - N. Broadway
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Margaret Waldman

3. (b) Social Security Number:

4. Sex: F.

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 7 - 1872

8. AGE: Years: 76 Months: 4 Days: 7 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: ✓

11. Industry or business:

FATHER
12. Name: Amos A. Waldman
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Laura V. Logue
15. Birthplace: Westminster, Md.

16. Informant: Cedar Crest N. Home Records
Address: Severna Park, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 2/18/1949 (month) (day) (year)

Cemetery or crematory: Hut Carmel Cem

Location: Baltimore - Md

18. Funeral director: F. B. Wippert & Son
Address: 1300 Eutaw Place

19. 2/18 1949 (Date rec'd by registrar) A.W. Hedrick Dr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1949 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/27/48 19 to 2/12/49 19 and that I last saw her alive on February 12 1949

Immediate cause of death	DURATION
General arterio sclerosis	?
Due to: Senility	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: G. H. Faulkner MD. M. D. or other

Address: Glen Burnie, Md. Date signed: 2/14/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.D 01345

CERTIFICATE OF DEATH

13d Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WATERBURY	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WATERBURY
LENGTH OF STAY (in this place)	STREET ADDRESS (If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ROSALIE	JACOBSEN	WALLIS		2	21	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE		1-26-1865	84 yrs.	0	26		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE	NONE	BALTIMORE MD	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN GORDON JACOBSEN	ROSALIE GILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	—	G. EVERETT WALLIS JR.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Intestinal Obstruction - Cause Undetermined	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-sclerotic Heart Disease	6 Months
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Jan, 19 47, to Feb 21, 19 49 that I last saw the deceased alive on Feb 20, 1949, and that death occurred at 11:25 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward J Merritt	M.D.	Gambrills Md	2-22-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	2-23-49	ST STEPHENS	MILLERSVILLE	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 23, 1949	E.T. Joyce Local Reg.	John M. Taylor Son	Annapolis Md.

RECEIVED
FEB 28 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

422.1 01346
93d

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville — LENGTH OF STAY (in this place): 1yr.7mos.26days	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crisfield, Maryland
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): unknown

3. NAME OF DECEASED (Type or Print)	(First) Sarah	(Middle) Anne	(Last) Ward	4. DATE OF DEATH	(Month) 2/23/49 (Day) (Year) 19
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify): unknown	8. DATE OF BIRTH: ~~unknown~~ Apr. 1864	9. AGE last birthday: 85(?) yrs.	If under 1 year: Months Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): unknown	12. CITIZEN OF WHAT COUNTRY? unknown		
13. FATHER'S NAME: unknown	14. MOTHER'S MAIDEN NAME: unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~(If year, give war or dates of service)~~	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myodegeneratio Cordis	known to us since 6/9/47
Antecedent cause(s)	(b) General Arteriosclerosis	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Senile Psychosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/9/47, 19....., to 2/23/49, 19....., that I last saw the deceased alive on 2/23/49, 19....., and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marquisten M.D.		Crownsville, Maryland	2/23/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE: Feb 28. 1949	NAME OF CEMETERY OR CREMATORY: Charles H Ward	LOCATION (City, town, or county): Crisfield (State): Md
DATE REC'D BY LOCAL REG.: 2/23/49	REGISTRAR'S SIGNATURE: E F. Joyce Local Registrar	24. FUNERAL DIRECTOR: Charles H Ward	ADDRESS: Marion Md

b281
S8
1761

RECEIVED
FEB 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2 01347
930

CERTIFICATE OF DEATH

Reg. Dist. No. 28!

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH
COUNTY Anne Arundel
MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 11½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Balto ~~City~~
CITY (If outside corporate limits, write RURAL and give nearest towo) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 503 W. Lenwal

3. NAME OF DECEASED (Type or Print) (First) Anita (Middle) (Last) Wise

4. DATE OF DEATH (Month) 2 (Day) 4 (Year) 1949

5. SEX Female

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH 1923?

9. AGE last birthday 25? yrs.
If under 1 year Months Days
If under 24 hr. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Schuyler Wise

14. MOTHER'S MAIDEN NAME Olivia Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	unknown
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Congenital Idiocy	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Mooth) (Day) (Year) (Hour)

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/41, 19..., to 2/4, 19.49., that I last saw the deceased alive on 2/3, 1949, and that death occurred at 5:45 AM m., from the causes and on the date stated above.

SIGNATURE Jacob Nugente M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 2/4/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE 2-7-1949 NAME OF CEMETERY OR CREMATORY Arbutus Mem Pk. LOCATION (City, town, or county) Baltimore Co. (State) Md.

DATE REC'D BY LOCAL REG. 2/7 REGISTRAR'S SIGNATURE A.L. Fedrick

24. FUNERAL DIRECTOR Wm. George H. Holland ADDRESS Druid Hill Ave.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.1 93d

01348

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
LENGTH OF STAY (in this place): 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 177 West St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
STREET ADDRESS (If rural, give location): 177 West St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Catherine (Last) Woodward

4. DATE OF DEATH: (Month) Feb. (Day) 15, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: March 17, 1865

9. AGE last birthday: 83 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Frank Tierney

14. MOTHER'S MAIDEN NAME: Katherine Barley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: -----

17. INFORMANT: Mr Howard Armiger

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardio-Vascular Disease — Interval between onset and death: 2 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute Cardiac Dilatation — Interval between onset and death: Immediate

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1949 to Feb. 15, 1949, that I last saw the deceased alive on Feb. 15, 1949, and that death occurred at 8:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Albert H. Anderson M.D. — ADDRESS: Annapolis, Md. — DATE SIGNED: Feb. 15, 1949.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 2-17-49 — NAME OF CEMETERY OR CREMATORY: St. Annes Cemetery — LOCATION (City, town, or county) (State): Annapolis A.A. Co. Md.

DATE REC'D BY LOCAL REG.: Feb. 17, 1949 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son, 170-172 West St. Annapolis, Md.

RECEIVED
FEB 18 1949
BUREAU V. S.